How Do Trainees Rate the Impact of a Short Cognitive Behavioural Training Programme on their Knowledge and Skills?

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How effective is a short cognitive behavioural skills training programme for mental health staff: an evaluation based on trainee, mentor and manager responses.

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How effective is a short cognitive behavioural skills training programme for mental health staff: an evaluation based on trainee, mentor and manager responses.

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Abstract: A strong evidence base for Cognitive Behavioural Therapy has led to CBT models becoming available within mainstream mental health services. As the concept of stepped care develops, new less intensive mental health interventions such as guided self help are emerging to be delivered by staff not trained to the level of accredited Cognitive Behavioural Therapists. These developments pose the question of how mental health staff can be trained in CBT concepts, models and techniques that can be integrated into their normal practice. **Method:** This study

evaluates the effectiveness of a short Cognitive Behavioural Therapy skills training programme provided with mentor support to mental health professionals in one region of the Irish Mental Health Service. The training was provided against a background of financial restraint and reorganisation of mental health services. **Results:** The training resulted in subjective gains in knowledge and skills that were maintained at 1 year follow up and improvements in practice and outcomes reported by trainees, mentors and managers **Conclusion**: A short well designed CBT skills programme can enable mental health staff to integrate basic CBT knowledge and skills into everyday practice producing improvements in practice and patient care.

Keywords: skills training, short courses, cognitive behavioural therapy, mental health staff, mentors, managers, practice, outcomes.

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Introduction

Cognitive Behavioural Therapy (CBT) is now an essential part of modern mental health services and recommended by clinical guidelines (NICE, 2004a; NICE, 2004b based on the robust evidence base from decades of empirical research. The impressive IAPT programme in England further increases access to CBT based programmes in England. In Northern Ireland a new Psychological Therapies Strategy (DHSSPS, 2009) is currently being implemented with CBT prominently featured

amongst other evidence based approaches. In the Republic of Ireland (ROI) a recent review of mental health services recommended major changes including: closure of the remaining psychiatric hospitals, development of community care teams and expansion of a comprehensive range of medical, psychological and social therapies stating “cognitive behaviour therapy and interpersonal therapies are often clinically effective as well as cost effective, and these should be available in the primary care network” (Government of Ireland, 2006, p. 63). The need for CBT training for mental health professionals in Ireland is highlighted in the recently published "Vision for Psychiatric and Mental Health Nursing (HSE, 2012). There are approximately 3195 therapists accredited in the United Kingdom by the CBT professional body, BABCP, but only 39 in the Republic of Ireland (BABCP, 2012) so it is difficult for patients in Ireland to access evidence based skilled therapists.

As policy changes incorporate the principle of evidence based practice at all levels of mental health care the training needs and competencies of the mental health workforce need to be considered. Therapist competency has been linked to improved patient outcomes (Grey, Salkovskis, Quigley, Clark and Ehlers, 2008; Milne , Baker, Blackburn, James and Reichelt,1999; Trepka, Rees, Shapiro, Hardy and Barkham, 2004) and competency standards for Cognitive Behavioural Therapists have been agreed (Roth and Pilling, 2008)

More recently, the question of how training can improve therapist competencies and patient outcomes has received attention (Bennet-Levy, McManus, Westling, and Fennell, 2009). The level of competence required for positive outcomes depends on the complexity of the patients’ presenting problems, for example higher competence

levels are necessary to provide effective Cognitive Therapy for severe, chronic, functionally impaired depressed patients (Coffman, Martell, Dimidjian, Gallop and Hollon, 2007).

Competency frameworks and maps have been developed (Roth and Pilling, 2008), models for conceptualising therapist skills development have been designed (Bennett-Levy, McManus, Westling and Fennell, 2009) and a range of effective training methods have been tested (Westbrook, McManus, Clark and Bennett-Levy, 2012).

Some studies have demonstrated that training can improve competencies in CBT trainees (Milne, Baker, Blackburn, James and Reichelt, 1999) and in primary care staff delivering Computerised CBT programmes (CCBT) (Rose et al, 2011). In contrast, other studies have found limited effects of teaching General practitioners brief CBT skills for Depression (King, et al., 2002). A more detailed and extensive review of existing research into the efficacy and effectiveness of CBT training has been published elsewhere (Rakovshik and McManus, 2010).

A stepped Care approach to mental health is now being developed throughout the U.K. supported by NICE guidelines (NICE, 2009). New and innovative CBT based services such as guided self help and CCBT are on offer for common mental health problems like depression and anxiety disorders. The increasing evidence base for such interventions has implications for service delivery and training implications for mental health practitioners in community mental health and primary care settings (Lovell and Richards, 2000).

Although there is limited data on the efficacy of CBT skills integrated into general mental health practice new programmes are being evaluated. The SPIRIT (Structured Psychosocial InteRventions in Teams) course trains practitioners in the use of CBT self-help workbooks (Williams, 2009) and has proven effective in a primary care randomized controlled trial (Williams, et al., 2007). The SPIRIT programme also produced encouraging results when provided for a large multi-disciplinary group (n=263) of in-patient based and community based mental health staff. Perceived subjective skills and knowledge and objective skills ratings were significantly higher than baseline scores at the end of the training and at 3-month follow-up (Williams, Martinez, Dafters and Ronald, 2011).

Context and Purpose

In recent years severe economic austerity measures have been introduced in Ireland which have had implications for funding of mental health services. Despite these challenges, a Regional Centre of Nursing and Midwifery Education (RCNME) in one region of the Health Service, HSE South (Carlow, Kilkenny, South Tipperary, Waterford and Wexford) located resources to finance a CBT foundation training programme for Nurses and other frontline mental health professionals. This multidisciplinary programme was comprised of basic knowledge and skills and similar to the SPIRIT initiative (Williams, Martinez, Dafters and Ronald, 2011) had a strong emphasis on enhancing participants existing professional repertoire. During the training period major mental health policy changes were being introduced including the closure of remaining psychiatric hospitals, transfer of services from institutional to community based services and significant changes to service delivery

and role definition. Many course participants were relocated into community based work settings within the time period of the training.

As part of the preliminary negotiations for the course, important organisational measures were agreed to enable learning to transfer into the practice area: (i) the support of Directors of Nursing, Heads of Discipline and line managers for the programme was secured, (ii) participants were facilitated to integrate CBT principles and skills in their work/practice settings and (iii) practice mentors were nominated to support participants in the integration of course learning into practice.

The purpose of this course was to add to the skills base of the existing workforce unlike the IAPT programme in England which had secured significant funding to train and employ a new group of psychological wellbeing practitioners at this level of practice.

Method

Study design

Participants were assessed at baseline, again following the training intervention, and finally at 12 months post training. Baseline knowledge and skills were assessed using self-report questionnaires. Changes to knowledge and skills were monitored throughout the course by mentors who completed post training questionnaires immediately after the training. Observed post training effects on professional practice with patients/clients were measured by questionnaires completed by mentors and

clinical managers. Clinical managers were also invited to respond on observed changes to outcomes.

Participants/ trainees

The training programme was offered to Nurses and other Health/Social Care Professionals who provided psychosocial interventions to mental health clients in the acute or community mental health settings and included staff from the voluntary and community sector. Trainees were selected by team managers in the south east of Ireland and approved by a director of nursing or equivalent senior clinical manager. A key principle underpinning the programme was to train the different professions together reflecting the multi-disciplinary nature of service provision in community care.

In total, 300 professionals attended the training in three cohorts over a 30 month period. This evaluation is based on the second cohort of 119 trainees, 102 of whom completed both the pre- and post-evaluation questionnaires agreeing to participate in the study (Of the 17 who did not take part in the evaluation, 12 did not complete the full training programme, 5 did not return post training questionnaires). Forty six trainees (45% of study participants) completed questionnaires at 1 year follow up.

Most participants were nurses and almost half the group worked with adults with a range of mental health disorders. The professional backgrounds were listed as follows: 64 nurses, 7 Counsellors, 6 Addiction Counsellors, 5 Psychologists, 4 Social Workers, 4 Occupational Therapists, 8 ticked the "others" box, and for 4 information was not provided. The majority were female (85%) and from a nursing background.

Participants described their work settings as follows: 42 worked in community mental health, 21 in acute psychiatric settings, 9 in psychiatric hospital, 6 in residential care, 4 in primary care, 3 in both hospital and community settings, 4 in general mental health, 3 in counselling services, 2 in Intellectual Disability, and 8 responded in the "other" category. In relation to patient and client groups, 52 worked with multiple mental health issues (e.g. depression, anxiety, bi-polar, schizophrenia, dual disorder), 15 with Addictions (alcohol, drugs, gambling), 9 with old age mental health, 6 with adults with intellectual disability, 6 with children and/or adolescents (including their families), 4 with adults who have experienced childhood trauma, 4 with self-harm or suicide, 2 with adults with Asperger Syndrome, 3 with people affected by suicide, traumatic death or bereavement and 1 with offenders.

Mentors and Managers

Practice Mentors for the programme were expected to meet the following requirements: hold a professional qualification in mental health or social care and have 3 years post qualification experience; have a sound understanding of mental health problems and current psychological interventions; have a working knowledge of CBT principles and practice. Mentors were asked to comment on practice change but not outcomes because they were not all in a position to observe ongoing interaction with patients over time. Clinical managers were asked to comment on practice and outcomes because they were expected to be more informed in this respect. Twenty four mentors completed questionnaires relating to 86 trainees (84% of participants) and 8 clinical managers responded relating to 33 trainees (32% of participants).

Course Content and Delivery

The content was designed by Dr Kate Gillespie drawing on principles from Adult Learning Theory (Kolb, 1984) with an integration of both intellectual and experiential learning. These learning outcomes were agreed by the teaching team and course planners as appropriate for teaching cbt knowledge and skills at this level and encompassed key concepts from the Declarative Procedural Reflective model (DPR) (Bennet-Levy, 2006). This model proposes three systems of learning summarised as follows; the Declarative system, which concerns the acquisition of knowledge and understanding of theoretical models; the Procedural system, which is essentially the development of skills, attitudes and protocols and finally the Reflective system which is a reflective process to enable refinement of declarative knowledge and procedural skills (Bennet-Levy, McManus, Westling and Fennell, 2009). Key learning methods proposed by the DPR model include; reading and lectures, modelling, role plays, self experiental work and reflective practice, all of which were included in the design of this programme. The course learning outcomes were: 'CBT Principles', 'Using a CBT Framework (5 part model)', 'Goal setting', 'Use of Homework', 'How to build a Collaborative Therapeutic Relationship', 'How to Structure therapeutic work', 'Use of Socratic Dialogue', 'Role of Negative and Biased Thinking', 'Re-evaluating Negative Automatic Thoughts', and 'Use of Thought Records and Simple Behavioural Experiments'.

Theoretical input and skills training was delivered over three two-day study blocks during a three month period. Participants were encouraged to practice their skills in between block study periods with the support of their Practice Mentors and Line Managers. The combination of direct class contact, self directed learning, clinical

practice and practice mentoring was designed to provide theoretical knowledge and understanding , facilitate development of practical skills in each trainee's practice setting, and finally provide opportunities for reflective learning on knowledge and skills development throughout the period of the training. The teaching method used a socratic approach, trainer role plays and DVDs to demonstrate application of knowledge and skills, trainee role plays to practice techniques and skills followed by small group discussions. Homework tasks were agreed after each teaching day usually to practice specific skill sets, observe, reflect and record comments, questions or learning points for discussion with mentors or at the next teaching session. The content, sequence of inputs and delivery methods were refined on the basis of feedback from the first cohort of trainees of the course and the modified programme was offered to the next cohort who provided the data for this study.

The training was provided by a Psychiatrist, a Senior Nurse and a Social Worker all of whom are qualified and experienced cognitive therapists. The programme was delivered at four separate sites in the South East of Ireland to ensure accessibility across the region.

Measures

Trainee self report questionnaires were used based on 10 point likert-style scales (0 - 9 none to sound) to measure change at pre, post and 1 year follow up on knowledge and skills levels (the final small group of trainees completed the FU questionnaires between 10 months - 12 months after the course ended). CBT principles was the only learning outcome measured as a knowledge factor but not as a skill. Trainees were also asked to respond to two questions, one relating to

practice and one relating to outcomes and offered space for qualitative comments in response to all questions.

Mentors used the same likert scales to record pre – post knowledge and skills scores and were also invited to make general or thematic comments based on observations of their group of trainees. Clinical/ team managers were asked to complete short questionnaires with comments on their observed impact of training on trainees practice and patient/client outcomes. Mentor and manager questionnaires were completed between 10 and 12 months after the training ended. All questionnaires were designed by the authors to evaluate items specific to the training provided, as no existing suitable questionnaires were located.

Data Analysis

Data was analysed using the statistical package SPSS version 15. Pre-, post-training and follow up scores in each of the learning outcomes for knowledge, understanding and skills were compared using paired t-tests. Frequency and thematic analyses were used to analyse manager and mentor responses.

Results

The results for changes in trainee knowledge and understanding suggest significant improvement ($p < .0001$) on all outcome variables following the 3 month period of the training and these pre - post training gains were maintained at 1 year follow up. (table 1). The mean group gains dropped between the post training period and follow up to varying degrees of significance for 6 outcome variables (CBT Principles;

using a CBT Framework (5 part model); goal setting; use of Socratic Dialogue; role of negative and biased thinking; re-evaluating negative automatic thoughts; and use of thought records and simple behavioural experiments)(table 1).

The results for changes in trainee skills suggest similar significant pre to post training gains on all skills outcomes ($p < .0001$) which were also maintained at one year follow up (table 2). In comparison, the mean group gains in skills increased for all of the skills outcomes during the post and follow up period increasing to varying degrees of significance on 5 variables (use of homework; how to use structure; use of Socratic Dialogue; role of negative and biased thinking; re-evaluating negative automatic thoughts) (table 2).

The pre-post Likert scale ratings from mentors also indicate significant post training improvements in knowledge and skills ($p<.0001$) (Table 3).

Insert table 1 here

Insert table 2 here

Insert table 3 here

Effects on practice

In response to the question "*has your practice changed in any way as a result of learning and applying these new skills*", all except one of the 96 trainees who responded reported that practice had improved with 40% responding that "practice had improved substantially", 59% responding that "practice had improved slightly" and 1 participant responding that "practice had deteriorated slightly." The responses of mentors and managers appear to support the self reported trainee impressions of practice improvement. The aggregated mentor (N=24) scores for 86 trainees (84% of participants) reported that practice had improved substantially for 64%, improved slightly for 28% and not changed for 8% of the group. The 8 managers who responded in relation to 33 trainees, (32 % of participants) reported that practice had improved for all their trainees, improved substantially for 75% and improved slightly for 25% of the group.

Effects on outcomes

In response to the question "*have your outcomes with clients changed in any way as a result of learning and applying these new skills*" of the 93 trainees who responded 25% replied that outcomes had improved substantially, 62% replied that practice had improved slightly, 12% replied that outcomes had not changed at all and 1 candidate replied that outcomes had deteriorated slightly. Nine participants did not answer the question in response to outcome changes, inserting comments such as:

(1)" *the question is "Not applicable yet"*

(2)" *Not enough clinical contact to justifiably quantify/rate this" and*

(3)"*It is early days yet".*

The 8 mangers who responded reported that outcomes with patients had improved for all their trainees; improved substantially for 75% of trainees and improved slightly for 25% of the group (N = 32 Trainees).

Discussion

These results suggest that the training course had an effect in increasing trainee CBT knowledge and skills at the end of a three month period of training which in turn had an observed effect on patient care. Interestingly, there was a drop in the mean scores on all knowledge variables in the period between post training and follow up although some of these changes were non-significant (table 1). In contrast, there were reported improvements on all skills outcomes between post training and follow up, 5 of which were statistically significant. There are a number of possible explanations for this difference, for example, at the 1 year time point, the results may have been reflecting memory and recall biases. Our impression, based on the qualitative comments from all sources, is that with practice, knowledge and understanding became less explicit over time but more implicit and applied in the form of enhanced skills development.

Another interesting point was the difference between trainee and mentor pre- training ratings on all variables (see tables 1, 2 and 3) with trainees tending to report higher perceived levels of knowledge and skills than mentor perceptions. However this variation was removed at post training ratings with trainee 1 year follow up mean scores and mentor mean scores very similar on all variables and both sets of ratings indicating post training increases in knowledge and skills.

The qualitative responses on the trainee questionnaires provide concrete examples of how the training has had an effect on practice and outcomes. Many of the participants had some prior form of training in counselling and the most beneficial changes in practice were reported as better structure in sessions, use of socratic dialogue and using a CBT framework to conceptualise clients problems (5 part model).

Some examples of trainee comments in relation to practice were:

> *Before completing CBT course my sessions would have no structure and I would do a lot of the talking and I would quickly review homework, this has all changed now and I feel my clients have benefited as a result*
>
> *Now able to put a much better structure on 1:1 work- has been so beneficial re: not to just sit for an hour with someone and listen to complaints!*
>
> *Aids nurses, used as a starting point and right through therapeutic relationship, focusing on achievable goals, taking small steps towards recovery*
>
> *Having the specific framework has probably made my practice more focused regarding client goals from the start of meeting clients*
>
> *Helped to structure sessions. Clients appear to value CBT as a tool. Very applicable to occupational therapy in terms of goal setting clients*
>
> *I find structure in an interview very useful and helps me focus on the important points. I realise now the importance of homework*

use of CBT principles and 5 part model, has been an invaluable tool used with clients. - increased awareness in clients how thoughts impact how you feel, become aware of negative biased thinking and learning to challenge and replace it.

The participant who responded that his/her practice had deteriorated slight commented:

'*I find that while applying skill learned that I feel more disjointed in my practice. I believe that this will improve as I practice more*.'

In relation to changes in outcomes, trainees responses were more varied than the positive "improvements to practice" comments but nonetheless reported improvements in several areas as the following responses indicate:

Having incorporated some CBT, another client who came depressed needed only 5 sessions. This result was amazing. I worked totally CBT with her and she loved the hand outs and homework

Clients feel secure in the structure of the session, they are reflective in the way they learn to recognise and 'catch' unhelpful thinking. The 5 part model is an effective way for them to decide on the areas and the changes they can make

Many of my clients would have serious and enduring mental illness - any changes will be slow and laborious

It's hard to identify if outcomes have changed. Problem behaviours are identified more quickly, so maybe.

More successful, sustained improvement for clients suffering from depression. One client has resolved very old issues with family and is now looking at reducing antidepressant medication

Number of sessions with clients has lessened - clients appear more positive

On discharge definite goals have been achieved

Clients exit after 8 sessions, concern I will have no caseload! Overall dramatic improvement on structure of sessions, supporting client in homework, behavioural experiments, I notice clients more engaged in process. Thought records great insight into clients internal world

The CBT course has had a significant impact on how I work with clients. My outcomes have greatly improved and as a result my satisfaction as a clinician has also significantly improved. I would welcome more training in this area and would recommend the training highly.

The participant who felt his/her client outcomes had deteriorated slightly commented that :

'I think they might have deteriorated due to possibly overestimating my previous knowledge.'

These mainly positive comments were supported by comments by mentors such as:

more focussed practice through use of structure; use of homework has been beneficial; training excellent, theory to practice and reviewing process worked excellently; given mentees new skills and framework for using existing skills; need for ongoing mentoring/supervision.

Similar comments were reported by clinical managers:

> *counsellors appear more knowledgeable in CBT and have enhanced counselling skills; given staff confidence and framework for practice; improvement in 1/1 contact with service users, service user input and participation is enhanced; more focused and goal orientated; therapy more structured, good therapeutic results; staff better equipped in dealing with various situations; audit suggests positive feedback from service users; staff and clients benefit hugely; would like to see all staff complete this course.*

In respect of course delivery, a number of factors were identified as beneficial: the importance of planning role plays carefully with clarity of purpose and linked to specific skills development and teaching; seeing principles in action in demonstrations is more effective than talking about them; using one case example throughout the entire teaching block and developing the role plays around this case helped make role plays more realistic; guiding trainees how to give structured parsimonious feedback to the group provided good training in how summarize and distil information.

The attitudinal shift toward CBT and practice is summed up in this general comment from a trainee:

> *To be honest prior to the training, with very little knowledge of CBT I would have considered it to be a 'quick fix' model 'sticking plaster'. Post training I have a hunger for more knowledge in this area as I can see the long and short term benefits of this work for my client.*

Role of Mentors

All trainees agreed to 10 hours of active participation in practice mentoring during the course. Service Managers agreed to maintain a practice mentor or similar support role for participants for a period following completion of the programme. The purpose of this arrangement was to encourage trainees to continue to utilise CBT skills in their practice. Review meetings with managers and anecdotal feedback suggest that most participants have continued to receive support for their practice within the teams following course completion. We see this as vital in maintaining knowledge transfer and ongoing skills development.

Limitations

There are a number of limitations in this study. The use of non-standardised measures to measure changes in knowledge, skills, practice and outcomes is a limitation which was partly compensated for by inviting specific examples in trainee comments. The use of patient clinical outcome measures would have provided a more objective measure of effects on clinical practice. The observations from managers and mentors were recorded to secure a different perspective on these important effects but we accept that these groups are also stakeholders in this project. The mentors returned the recorded pre- and post scores at the end of the course so there may have been scope for retrospective bias. It would also have been desirable to have had a higher follow up response rate from trainees but in the circumstances of major organisational and staff changes the response rate is understandable. Similarly, there was a relatively low rate of manager responses but we recognise the demanding workloads on mental health managers particularly during the period of this study.

Conclusion

The results suggest that it is possible to provide a short well designed CBT "skills for practice" course that can add to the skills base of front line mental health practitioners similar to findings from other such initiatives (Williams et al., 2011). Encouragingly, the results suggest that even in a challenging economic climate and an uncertain time of major organisational restructuring, staff can be motivated to participate in such an innovative training initiative if it is clearly linked to improving patient care. This study does not suggest that a such a short programme should replace university post graduate programmes to train accredited Cognitive Behavioural Therapists. In Ireland, this is an identified gap in CBT service provision, and we accept that this programme should not be seen as a quick, more cost effective alternative to higher level training programmes. Nonetheless, there is a need for appropriate training to respond to patient needs at all levels of care within newly emerging stepped care models. Such short courses can complement more advanced CBT training programmes and enhance skills development of staff in acute and community mental health teams.

One important general outcome from the course and this evaluation has been a recent decision by Health Service Executive in Ireland to develop a national "CBT skills for practice" programme to support clinical practice in mental health services throughout the country. The national programme will be substantially based on the learning and outcomes from this study. An additional outcome of this short course has been to stimulate interest amongst participants for more advanced level post graduate diploma training in CBT. Both outcomes can help to increase access to evidence based psychological therapies for service users to in Ireland.

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Table 1: Pre, post and follow up training scores for knowledge and understanding compared using paired t-tests

	Knowledge/understanding					
Learning outcome	**Pre-training Mean (SD)**	**Post-training Mean (SD)**	***Pre-post training t***	**1 year follow up Mean (SD)**	***Pre- training- 1 year follow up t***	***Post-training – 1 year follow up t***
CBT Principles	3.4 (1.6)	7.6 (1.0)	-24.85***	6.8 (1.3)	-14.02 ***	3.75**
Using a Framework	2.6 (2.0)	7.7 (1.0)	-25.50***	7.3 (1.1)	-15.40***	2.77*
Goal setting	4.8 (2.1)	7.6 (1.0)	-14.24***	7.3 (1.3)	-7.42***	2.21*
Use of Homework	4.3 (2.3)	7.7 (1.0)	-14.31***	7.5 (1.2)	-8.70***	1.32
Building a Collaborative Therapeutic Relationship	5.2 (2.4)	7.8 (1.0)	-12.07***	7.7 (1.2)	-12.07***	0.70
How to Structure therapeutic work	4.2 (2.1)	7.5 (1.0)	-16.04***	7.2 (1.2)	-16.04***	1.98
Use of Socratic Dialogue	2.1 (2.3)	7.3 (1.2)	-21.36***	6.9 (1.3)	-21.36***	2.85*
Role of Negative and Biased Thinking	4.1 (2.3)	7.3 (1.2)	-14.05***	7.1 (1.4)	-14.05***	1.68
Re-evaluating Negative Automatic Thoughts	3.5 (2.4)	7.0 (1.3)	-15.43***	6.8 (1.4)	-10.31***	2.17*
Use of Thought Records and Simple Behavioural Experiments	3.1 (2.2)	7.3 (1.2)	-18.20***	6.8 (1.5)	-9.20***	3.46**

*** significant at p<.0001 level, ** significant at p<.001, * significant at p<.05

Table 2: Pre, post and follow up training scores for skills compared using paired t-tests

Learning outcome	Pre-training Mean (SD)	Post-training Mean (SD)	*Pre-post training t*	Skills 1 year follow up Mean (SD)	*Pre- training- 1 year follow up t*	*Post-training – 1 year follow up t*
Using a Framework	3.0 (2.1)	6.5 (1.5)	-14.70***	6.8 (1.3)	-10.767 ***	-1.17
Goal setting	4.6 (2.1)	6.7 (1.6)	-9.80***	7.0 (1.3)	-6.566 ***	-1.42
Use of Homework	3.9 (2.3)	6.6 (1.5)	-10.54***	7.0 (1.7)	-7.684 ***	-2.09*
Building a Collaborative Therapeutic Relationship	5.2 (2.4)	7.2 (1.6)	-8.26***	7.5 (1.4)	-6.652 ***	-1.67
How to Structure therapeutic work	4.0 (2.1)	6.4 (1.7)	-10.17***	6.7 (1.5)	-7.641 ***	-7.64***
Use of Socratic Dialogue	1.9 (2.2)	6.1 (1.6)	-16.33***	6.3 (1.5)	-9.551 ***	-9.55***
Role of Negative and Biased Thinking	3.8 (2.2)	6.5 (1.6)	-10.81***	6.9 (1.4)	-7.480 ***	-2.34*
Re-evaluating Negative Automatic Thoughts	2.9 (2.2)	5.8 (1.9)	-11.55***	6.6 (1.5)	-9.754 ***	-2.86*
Use of Thought Records and Simple Behavioural Experiments	2.8 (2.1)	5.8 (1.9)	-12.30***	6.4 (1.7)	-9.976 ***	-1.99

*** significant at p<.0001 level, ** significant at p <.001, * significant at p <.05

Table 3: Mentor ratings of trainee pre- post knowledge and skills compared using paired t-tests (24 mentors - 86 trainees)

Learning outcome	Pre-training Mean (SD)	Post-training Mean (SD)	*t*	
Using CBT knowledge & Framework	2.0 (1.0)	6.61 (1.2)	-30.76	***
Goal setting	2.8 (1.0)	7.3 (0.9)	-24.88	***
Use of Homework	2.2 (1.1)	7.0 (1.2)	-24.43	***
Building a Collaborative Therapeutic Relationship	4.1(1.7)	7.8 (0.9)	-18.37	***
How to Structure therapeutic work	2.3 (1.0)	6.8 (1.2)	-23.41	***
Use of Socratic Dialogue	2.0 (1.4)	6.4 (1.1)	-25.29	***
Role of Negative and Biased Thinking	2.9 (1.2)	7.1(1.1)	-22.99	***
Re-evaluating Negative Automatic Thoughts	2.3 (1.4)	6.9 (1.0)	-27.68	***
Use of Thought Records and Simple Behavioural Experiments	1.8 (1.1)	6.5 (1.2)	-27.50	***

*** significant at p<.0001 level